Viewpoint

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Viewpoint

Trust and the sociology of the professions

There is a fast-growing literature on trust in health care, especially interpersonal trust, but also public or institutional trust, reflecting the growing awareness in both the research and policy communities of the importance of trust. At a general level, trust as part of the broader concept of social capital is related to people's health and well-being. Trust within provider-patient relations is important for its non-specific treatment effects. Finally, trust is also important for the smooth functioning of societal institutions. Rosemary Rowe and Michael Calnan[1] discuss some of this literature in order to develop a 'new agenda' for research. I agree with most of what they write, but I think the research agenda needs further elaboration. Basically, I think that the developments Rowe and Calnan described in their contribution are much broader than just health care in three respects. First of all, the causes of erosion of trust are largely general societal developments. Second, these developments not only affect trust of patients in health care providers but also trust of health care providers in each other and trust in third parties. Thirdly, not only health care is affected, but also other areas of service delivery that share some of their characteristics with health care. A new research agenda should take this into account and develop a new contribution to the stagnating field of the sociology of the professions.

Societal and health care changes

As Rowe and Calnan argue, the nature of trust relations is changing. And even though institutional guarantees for good quality care (and the actual quality of care) might be better for physicians working in large modern organizations, people tend rather to place trust in a personal doctor whom they know and have confided in during previous episodes of care. A number of broader societal changes that also affected health care, have influenced trust relations:

—Increasing specialization and division of labour; in the field of health care both horizontal (between medical specialisms) and vertical (between doctors and nurses) division of labour are changing.
—Increasing organizational scale; the size of both hospitals and primary care organizations is still increasing and changing from partnerships of equals[2] to bureaucratic organizations.
—Standardization of service delivery; the introduction of quality systems and guidelines have changed professional autonomy and shifted power towards third parties.[3]
—Increasing consumerism and self-reliance of service users; information asymmetry decreases as a consequence of information technology developments and standardization, but still calculating clients transform into vulnerable patients when illness strikes.
—Penetration of markets and commercialization; health care reforms in the past two decades aimed at introducing market elements in health care. European Union competition law has changed the position of professional organizations from normative communities into trade organizations.[4]
—Internationalization; medicine and health care are part of global networks; commercial hospital chains are starting to discover Europe, and cross-boarder utilization and international migration of health care personnel are increasing.

Trust problems in three types of relationships

All these developments affect trust relationships. However, not only trust between patients and providers is affected. Also the relationships of mutual trust between health care providers change as a consequence of changes in the system of professions[5] and organizational changes. A third type of relationship concerns the relationships of both health care users and providers with third parties. Relevant third parties are the owners of health care facilities, inspectorates, insurance and funding organizations and the government. There are two important issues for a research agenda. The first is how the central trust relation between clients and professionals is affected by changes in the two other types of relationships. As an example, the relationship between health care providers and insurance organizations in managed care in the US has affected the trust relation between doctors and their patients.[6] The second is whether trust relations always have a positive impact; strong trust in the wrong persons might be dangerous. We need to elaborate the conditions for positive and negative effects of trust.

Broader perspective: sociology of the professions

The sociology of the professions seems to be stagnating. Trust as a research area is developing independent of the sociology of the professions. The classical approaches to the sociology of the professions seem to be unable to account for the major societal changes, mentioned above, and their consequences for trust relations and the governance of these relations. The classical, functionalist approach to the professions fails to take into account the changing information asymmetry between professionals and their clients. The professional dominance and power approach[7] fails to account for the changes due to increased managerial control in the professions. Finally, the system approach[5] fails to take into account new developments in the division of labour (vertical differentiation and multidisciplinary groups).

Theoretically, this broader perspective could be fed by developments in social capital theory,[8] models on embeddedness of interactions in dyadic relations, broader social networks and institutions,[9] and transaction costs and agency theory.[10]

Towards a research agenda

In my view, the research agenda on trust in health care should contain theoretical elaboration and empirical research in comparative perspective. The comparative perspective should be both in terms of countries, as Rowe and Calnan suggest, and professions. Some of the societal changes, mentioned earlier, have had a stronger or earlier impact on other service professions. As an example, organizational scale and international orientation are much further developed in the accounting profession compared to the medical profession. The legal profession shows an interesting mix of individual persons and collective actors as clients. Standardization is much further developed in the notary. Also for

inter-country comparisons of trust relations in health care, it is important to identify countries that show particular developments that are relevant from a theoretical point of view. One could think of variations in institutional guarantees, such as patient charters, in the introduction of patient choice in social health insurance systems, and in contracting arrangements.

References

1 Rowe R, Calnan M. Trust relations in health care: the new agenda. *Eur J Pub Health* 2006;16:4–6.

2 Freidson E. *Doctoring together: A study of professional social control.* Amsterdam: Elsevier, 1975.

3 Timmermans S, Berg M. *The gold standard: An exploration of evidence-based medicine and standardization in health care.* Philadelphia: Temple University Press, 2003.

4 Batenburg R, Groenewegen PP. Vrije beroepen in Europa: de verschuivende grenzen van de nationale mededingingswetgeving. In: Arts W, Batenburg R, Groenewegen P, editors. *Een kwestie van vertrouwen:over veranderingen op de markt voor professionele diensten en in de organisatie van vrije beroepen.* Amsterdam: Amsterdam University Press, 2001.

5 Abbott A. *The system of professions: an essay on the division of expert labor.* Chicago: University of Chicago Press, 1988.

6 Kao AC, Green DC, Zaslavsky AM, Koplan JP, Cleary PD. The relationship between method of physician payment and patient trust. *JAMA* 1998;280:1708–14.

7 Johnson TJ. *Professions and power.* London: MacMillan Press, 1972.

8 Flap HD. No man is an island: the research program of a social capital theory. In: Favereau O, Lazega E, editors. *Conventions and structures in economic organization.* Cheltenham: Edward Elgar, 2002.

9 Lazega E. *The collegial phenomenon: The social mechanisms of cooperation among peers in a corporate law partnership.* Oxford: Oxford University Press, 2002.

10 Banks D. Transaction cost economics and its applications to health services research. *J. Health Serv. Res. Policy* 1996;1: 250–2.

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Trust relations in health care—the new agenda

Introduction

Trust has traditionally been considered a cornerstone of effective doctor–patient relationships. The need for interpersonal trust relates to the vulnerability associated with being ill, the information asymmetries arising from the specialist nature of medical knowledge, and the uncertainty and element of risk regarding the competence and intentions of the practitioner on whom the patient is dependent. Without trust patients may well not access services at all, let alone disclose all medically relevant information. Trust is also important at an institutional level, as trust in particular hospitals, insurers and health care systems may affect patient support for and use of services and thus their economic and political viability. However, in our so-called post-traditional order[1] is trust still necessary? The days of 'doctor knows best' when patients blindly trusted in and deferred to medical expertize are fast becoming a distant memory in industrialized societies where the consumer is dubbed 'king' and where the 'expert patient' expects to play an active part in decision-making regarding their treatment. Might lower levels of trust, or in fact distrust, be merited in light of medical errors, drug side effects, and the slow adoption of 'evidence-based' medical innovations and clinical guidelines? In this paper we set out how and why trust relations in the healthcare context are changing, arguing that although trust may now be more conditional it is still vitally important for both health care providers and institutions.

How have trust relations changed?

Trust relationships are characterized by one party, the trustor, having positive expectations regarding both the competence of the other party, the trustee, and that they will work in their best interests.[2] In the context of healthcare there have been changes to both interpersonal trust relations and to institutional trust relations.

Traditionally, patients have placed high levels of trust in health care professionals. Such interpersonal trust relations have been typified by a type of blind, embodied trust that developed as a result of a patient's knowledge of and relationship with their personal physician. Institutional trust in health care practitioners in general, health care organizations and systems have also tended to be high. This may well have been the effect of patients' high level of interpersonal trust in their doctor, and also have been due to clinician's professional status, and the relatively recent provision of health care as a state guaranteed welfare right. However, we would argue that these relationships have been fundamentally altered by changes in the organizational structure of medical care and the culture of health care delivery which have been prompted by wider social change. Public attitudes towards professionals and their authority as medical experts are changing, reflecting a more general decline in deference to authority and trust in experts and institutions, together with increasing reliance on personal judgments of risk.[3] The days of blind trust in a doctor 'who knows best' have been consigned to history. These broader social and cultural processes that have encouraged change in interpersonal trust relations have also stimulated changes in institutional trust. Beliefs about the limits of medical expertize together with concerns about the effectiveness of professional regulatory systems to ensure high standards of clinical care, highlighted by the media coverage of medical errors and examples of medical incompetence, have eroded trust in health care organizations, in the medical professions in general, and in health systems as a whole. Levels of public trust in individual clinicians may remain high but levels of trust and confidence in managers is considerably lower, a UK study[4] found that $<40\%$ had a great deal of confidence in them compared with over 80% who always trusted doctors or nurses.

The lower level of institutional trust and the emergence of more informed and potentially demanding patients who are aware that expert knowledge may be contested and who may actively seek further opinions and treatment options poses challenges for both